DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

COLOMBIA

PROGRAM FOR THE REORGANIZATION, REDESIGN AND MODERNIZATION OF HEALTH SERVICE NETWORKS

(CO-0139)

LOAN PROPOSAL

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ANNEXES

BASIC SOCIOECONOMIC DATA

For basic socioeconomic data, including public debt information, please refer to the following address:

http://www.iadb.org/RES/index.cfm?fuseaction=externallinks.countrydata

INFORMATION AVAILABLE IN THE RE3/SO3 TECHNICAL FILES

Preparation:

CONPES document 3204. Republic of Colombia, National Planning Department, Bogotá, 2002.

National Development Plan 2003-2006. Office of the President of the Republic, National Planning Department, Bogotá, 2002.

Performance of hospitals at the secondary and tertiary care levels restructured in 1999. Ministry of Social Protection, Bogotá, 2002.

Plan for reorganization, redesign and modernization of health service supply networks. Ministry of Social Protection, Bogotá, 2003.

Ministry of Health. Household survey analysis contracted with Econometría, Bitrán Asociados and ESAP. Bogotá, 2001.

Execution:

Operating Regulations (complete draft).

Standard performance contract between the National Government and the Department.

Template for diagnostic study of departmental health networks.

ABBREVIATIONS

ARS	Administradora del Régimen Subsidiado [Subsidized Regime Management Body]
CONPES	Consejo de Política Económica y Social [Economic and Social Policy Council]
DNP	Departamento Nacional de Planeación [National Planning Department]
DTS	Dirección Territorial de Salud [Subnational Health Directorate]
EPS	Empresa Promotora de Salud [Health promotion institution]
ESE	Empresa Social del Estado [State social enterprise]
FOSyGA	Fondo de Solidaridad y Garantía [Solidarity and Guarantee Fund]
GDP	Gross domestic product
IMF	International Monetary Fund
IPS	Institución Prestadora de Servicios [Health service provider]
IRR	Internal rate of return
ISS	Instituto de Seguros Sociales [Social Insurance Institute]
MHCP	Ministry of Finance and Public Credit
MPS	Ministry of Social Protection
OC	Ordinary Capital
PBL	Policy-based loan
PCU	Project coordinating unit
POS	Plan Obligatorio de Salud [Compulsory health plan]
PTI	Poverty-targeted investment
SBA	Standby arrangement (IMF)
SDS	Social development strategy
SEQ	Social equity
SGP	Sistema General de Participaciones [General revenue-sharing system]
SGSSS	Sistema General de Seguridad Social en Salud [General System of Social Security for Health]
SISBEN	Sistema de Selección de Beneficiarios [Beneficiary selection system]
UBN	Unmet basic need
UPC	Unidad de Pago por Capitación [Capitation grant]

INTERAMERICAN DEVELOPMENT BANK
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COLOMBIA

IDB LOANS

APPROVED AS OF OCTOBER 31, 2003

	US$Thousand	Percent
TOTAL APPROVED	**10,818,832**	
DISBURSED	9,617,892	88.89 %
UNDISBURSED BALANCE	1,200,940	11.10 %
CANCELATIONS	982,240	9.07 %
PRINCIPAL COLLECTED	4,858,665	44.90 %
APPROVED BY FUND		
ORDINARY CAPITAL	10,004,771	92.47 %
FUND FOR SPECIAL OPERATIONS	751,556	6.94 %
OTHER FUNDS	62,505	0.57 %
OUSTANDING DEBT BALANCE	**4,759,227**	
ORDINARY CAPITAL	4,571,776	96.06 %
FUND FOR SPECIAL OPERATIONS	187,161	3.93 %
OTHER FUNDS	289	0.00 %
APPROVED BY SECTOR		
AGRICULTURE AND FISHERY	558,414	5.16 %
INDUSTRY, TOURISM, SCIENCE AND TECHNOLOGY	524,890	4.85 %
ENERGY	2,804,190	25.91 %
TRANSPORTATION AND COMMUNICATIONS	729,109	6.73 %
EDUCATION	86,884	0.80 %
HEALTH AND SANITATION	752,748	6.95 %
ENVIRONMENT	129,501	1.19 %
URBAN DEVELOPMENT	561,908	5.19 %
SOCIAL INVESTMENT AND MICROENTERPRISE	2,744,959	25.37 %
REFORM AND PUBLIC SECTOR MODERNIZATION	1,891,715	17.48 %
EXPORT FINANCING	0	0.00 %
PREINVESTMENT AND OTHER	34,514	0.31 %

* Net of cancellations with monetary adjustments and export financing loan collections.

COLOMBIA

STATUS OF LOANS IN EXECUTION

AS OF OCTOBER 31, 2003

(Amount in US$ thousands)

APPROVAL PERIOD	NUMBER OF PROYECTS	AMOUNT APPROVED*	AMOUNT DISBURSED	% DISBURSED
REGULAR PROGRAM				
Before 1997	**8**	**236,983**	**187,270**	**79.02 %**
1997 - 1998	**8**	**208,627**	**165,787**	**79.47 %**
1999 - 2000	**4**	**344,100**	**150,063**	**43.61 %**
2001 - 2002	**5**	**500,700**	**400,943**	**80.08 %**
2003	**4**	**1,814,000**	**1,000,000**	**55.13 %**
TOTAL	**29**	**$3,104,410**	**$1,904,063**	**61.33 %**

* Net of cancellations. Excludes export financing loans.

Inter-American Development Bank
Regional Operations Support Office
Operational Information Unit

Colombia

Tentative Lending Program

2003

Project Number	Project Name	IDB US$ Millions	Status
CO0268	Social Emergency Program	1,250.0	APPROVED
CO0258	Attorney General's Office Support & Strengthening	14.0	APPROVED
CO0265	Health and Social Security Reform Program	400.0	APPROVED
CO0241	Social Housing Program	150.0	APPROVED
CO0139	Program for the Reorganiz., Redesign and Moderniz. of Health Services Networks	72.0	
	Total - A : 5 Projects	**1,886.0**	
	TOTAL 2003 : 5 Projects	**1,886.0**	

2004

Project Number	Project Name	IDB US$ Millions	Status
CO0266	National Public Service Modernization Program	18.3	
CO0263	Infrastructure Privatization and Concessions II	5.0	
CO0262	National Environmental System Support Program	35.0	
CO1001	Transport Sector Support Program	200.0	
CO0270	Public Services Sector Reform Program	600.0	
	Total - A : 5 Projects	**858.3**	
	TOTAL - 2004 : 5 Projects	**858.3**	
	Total Private Sector 2003 - 2004	**0.0**	
	Total Regular Program 2003 - 2004	**2,744.3**	

*** Private Sector Project**

PROGRAM FOR THE REORGANIZATION, REDESIGN AND MODERNIZATION OF HEALTH SERVICE NETWORKS

(CO-0139)

EXECUTIVE SUMMARY

Borrower:	Republic of Colombia	
Executing agency:	Ministry of Social Protection (MPS)	
Amount and source:	IDB (OC):	US$72,000,000
	Local:	US$18,000,000
	Total:	US$90,000,000
Financial terms and conditions:	Amortization period:	20 years
	Grace period:	4 years
	Execution period:	4 years
	Disbursement period (maximum 4 years, minimum 3 years):	4 years

The interest rate, credit fee, and inspection and supervision fee mentioned in this document are established pursuant to document FN-568-3 Rev. and may be changed by the Board of Executive Directors, taking into account the available background information, as well as the respective Finance Department recommendation. In no case will the credit fee exceed 0.75%, or the inspection and supervision fee exceed 1% of the loan amount.[1]

Interest rate:	Adjustable option
Inspection and supervision:	0%
Credit fee:	0.25%
Currency:	US dollars from the Single Currency Facility

[1] In no case will the inspection and supervision fee exceed, in a given six-month period, the amount that would result from dividing 1% of the loan amount by the number of six-month periods in the original disbursement period.

Objectives:

The main objective of this program is to support changes in public hospital management by raising the efficiency and quality of service provision. This will help to make public health service networks technically and financially viable, and allow for an expansion of insurance coverage within the SGSSS framework.

The program's specific objectives are: (i) to enhance the efficiency and quality of public hospital health services in a context of medium-term financial sustainability, under the managed competition framework established by the health sector reform. This will involve actions to assist public health service providers (IPSs), subnational health directorates (DTSs) and the Ministry of Social Protection (MPS); functional integration of IPSs in health service networks; implementation of human resource rationalization measures, and modification of the incentives regime in operational funding linked to output and quality targets; and (ii) implementation of a system to monitor and evaluate the performance of health service supply networks.

Description:

The program consists of two components: (i) operational reorganization of public hospital networks through performance contracts signed between the national government and the DTSs; and (ii) monitoring and evaluation. The first component lends support to the sector at the subnational level (departments and municipios) and supports IPSs with activities involving technical assistance, information system development and rationalization of human resources. The second component will finance technical assistance and information-system development activities in the sector's governing body (MPS), for monitoring and evaluating the service delivery policy and the program. The program is expected to cover approximately 132 public IPSs, or 20% of the nationwide total (see paragraph 2.6).

Relation between the project and the Bank's country and sector strategy:

In terms of the fundamental areas of the Bank's strategy with the country, the operation will mainly contribute towards the goal to promote social development and ensure protection for the most vulnerable population groups: firstly, by supporting a move from supply subsidies to demand subsidies, which will make it possible to extend health insurance coverage through the subsidized regime to the poorest population groups; and secondly, through progress in modernization of public hospitals, which will help to secure social services that are financially sustainable, more effective in addressing the population's needs and more resource-efficient. Protection of human capital investment, by improving health conditions, raises the economy's growth potential and thus supports the objective of laying foundations for reviving and energizing the economy. In addition, the

process of reorganization, redesign and modernization among health service providers should promote efficiency in the State and improve governance, thereby addressing the goal of improving governance in Colombia and supporting the State reform process (see paragraphs 1.40 through 1.42).

In terms of the fundamental areas of the Bank's social development strategy (SDS), this operation will contribute mainly to the first SDS objective, by supporting a health reform process that aims to extend the coverage of health insurance and promote efficiency in the use of public resources allocated to the sector (see paragraphs 1.43 and 1.44).

Coordination with other multilateral development agencies:

The effort to support Colombia both in reform implementation and in funding is being coordinated between multilateral agencies and the national government. Under sectoral support, the IDB and the World Bank are working together to protect expenditure aimed at financing an extension of the subsidized healthcare regime. Although the World Bank does not currently have operations in the health sector, the project team has exchanged information with it in order to coordinate the policy dialogue in the sector (see paragraph 1.56).

Environmental and social review:

Given its special characteristics, the program does not include physical or other investments, so it is unlikely to have a direct environmental impact. At its meeting of 7 July 2003, the Committee on Environment and Social Impact (CESI) recommended that sociocultural and environmental norms, manuals and guidelines be developed and implemented, as part of the institutional strengthening activities in subnational bodies to be funded by the program. This would enhance healthcare and access to health services for indigenous and Afro-descendent populations within the SGSSS framework (see paragraph 4.9).

Benefits:

In the medium term these efforts are expected to produce a substantial reduction in the operational and cumulative deficits, and make progress towards universal health insurance. This set of reforms is complemented by other Bank operations which are either in execution or currently being prepared.

In the absence of the actions envisaged in this program, it is calculated that the annual operating deficit will vary between 221 billion Colombian pesos (about US$73 million) in 2003 and 371 billion pesos in 2009 (about US$123 million). The initiatives proposed in this program will produce a substantial reduction in the operating deficit of public hospitals over the medium term. On the basis of fiscal savings likely to be achieved in 2004-2006, the program's financial internal rate of return (IRR) is estimated at 15%. If one considers

savings over the period 2004-2010, the IRR would rise to 28%. The payback period for the investment implied by severance payments is estimated at 27 months for the whole program.

As regards social impact, the program is expected to make access to health services more equitable, improve the efficiency and quality of services provided to the poorest groups and rural populations that rely on public institutions, and make progress towards universal health insurance (see paragraph 4.6).

Risks: There is a general risk relating to the government's political will to persevere with the reform process. Specific risks include the following: (i) after the rationalization process implemented under the program, IPS staffing may expand once more; (ii) actions to rationalize public supply and reduce staffing in health service establishments could generate a political risk to the program; and (iii) external factors, such as fiscal and financial crisis in subnational entities, represent a major risk to the viability of public hospitals. Risk is mitigated (i) by incentives built into the performance contracts, supported by annual assessments of progress on compliance and a clause preventing the rehiring of laid-off staff. With regard to (ii), this will be mitigated through labor retraining actions and severance payments financed by the program. Risk (iii) will be mitigated by including this program within the departmental fiscal adjustment process (see paragraphs 4.10 through 4.12).

Special contractual clauses: The selection and hiring of technical and administrative-financial directors for the project coordination unit (PCU) (see paragraph 3.15), and entry into effect of the operating regulations (paragraph 3.16) are conditions precedent to the initial disbursement.

Poverty-targeting and social sector classification: This operation qualifies as a social equity enhancing project, as described in the indicative targets mandated by the report on the Bank's Eighth General Increase in Resources (document AB-1704). The operation also qualifies as a poverty-targeted investment (PTI) (see paragraph 4.7). The borrower will be making use of the 10 percentage points in additional financing (see paragraph 4.8).

Exceptions to Bank policy: A revolving fund is being requested, with up to 10% of the loan funds (see paragraph 3.21), in accordance with Operations Administration Manual section 345 (OA-345).

Procurement: International competitive bidding (ICB) will be required for project procurements worth US$350,000 or more in the case of goods and US$200,000 and above for consulting services. Bidding processes in procurements for smaller amounts will be conducted in accordance with national legislation (see paragraph 3.17 through 3.20).

In the case of consulting service contracts for amounts under US$200,000, bidding processes will follow the corresponding Bank procurement procedures, which in this case allow for procurement notices to be published only nationally, and permit the executing agency to waive the formal prequalification process for drawing up a short list of qualified firms to be invited to submit bids. The procurement plan is attached as Annex 2.

I. FRAME OF REFERENCE

A. Socioeconomic setting

1.1 Since the second half of the 1990s, the Colombian economy has slowed down substantially. Following a brief growth bubble during 1998, in the first quarter of the following year Colombia entered its first major economic crisis of the last 70 years. In 1999 and 2000, the country simultaneously faced a declining GDP, crisis in the financial system and among mortgage debtors, and fiscal crisis at the subnational level, compounded by the emergence of contingent liabilities (pensions and infrastructure concession guarantees), and a growing imbalance in central government public finances. All these problems arose against a backdrop of restricted access to external funding and increased activity by violent groups.

1.2 These developments forced households and firms to make economic adjustments to reflect their new balance sheet situation. By 2001, the private imbalance had basically disappeared; the financial sector had overcome the crisis and was implementing a program to restructure subnational finances. On taking office in August 2002, the new administration confronted the economic and social effects of prolonged stagnation and fiscal imbalance by introducing structural reforms, to bring the deficit under control and energize the economy. These policies have begun to have a favorable impact, since the Colombian economy is now showing signs of a revival of productive activity. Although in 2002 the growth rate was only 1.6% (slightly above the previous year's figure), an expansion of between 2.5% and 3% is projected for 2003, compared to the 2% originally programmed.[2]

1.3 A US$2.2 billion standby arrangement (SBA) was agreed with the International Monetary Fund (IMF) in January 2003 and will serve as a macroeconomic policy framework for this year and the next. The program assumes a growth rate of 2% in 2003 and 3.3% in 2004. Targets for inflation, the current-account deficit and the fiscal deficit are shown in Table I-1.

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[2] The confidence of international markets has improved during 2003, and the outlook is optimistic. The EMBI+ index has fallen from 1,100 basis points in September 2002 to fluctuate in a range of 450-500 b.p. in the second quarter, thereby improving Colombia's position in relation to other emerging markets.

Table I-1. SBA targets

	2002	2003	2004
Annual rate of growth (%)			
Real GDP	1.6	2.0	3.3
Inflation	6.0	5.5	4.0
As a percentage of GDP			
Current-account deficit	-1.7	-0.8	-1.6
Deficit of the consolidated public sector	-4.0	-2.5	-2.1

Source: IMF

1.4 Keeping the fiscal situation under control continues to be the main challenge facing the government for 2004. The budget for that year projects a deficit of 2.5% of GDP, which exceeds the 2.1% target agreed with the IMF, and the results of the recent referendum could complicate the fiscal situation still further. To mitigate this, the government is proposing to send a package of measures to Congress that would enable it to raise fiscal revenue levels (increase in VAT, introduction of a temporary wealth tax, a pensions tax, among others).

1.5 Any fiscal deficit has to be funded. The financial program for 2004 projects central government borrowing requirements at US$9.1 billion (11.7% of GDP). Half of this is expected to be used for debt amortization and the other half to finance the central government deficit. Multilateral agencies are expected to be the main source of financing, as was also the case in 2003.

1.6 The growth of social spending during the 1990s reflected an effort by the country to ensure stable funding for the social sectors, especially in health and education.[3] Nonetheless, the additional funds made available failed to produce the expected efficiency gains in social spending. Between 1997 and 2001, the size of the population living below the poverty line grew, as did the number of people living in extreme poverty. This situation has led the current government to redouble efforts to improve the efficiency of service delivery.

B. The health sector in Colombia

1. Health problems

1.7 Colombia has experienced significant demographic and epidemiological changes over the last two decades, including population ageing, declining fertility, rapid urbanization, persistence of transmissible illnesses and a surge in non-transmissible diseases. By 2000, life expectancy at birth had risen to 70.6 years, fertility had dropped to 2.8 children per woman, and 71% of the total population was living in urban areas.

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[3] Between 1991 and 1999, public-sector social spending rose from 8% to 13%.

1.8 The available figures reveal two contrasting trends in the health domain. Maternal and infant mortality have both fallen substantially: the first from 120 deaths[4] per 100,000 births in 1995 to 91.7 in 1999,[5] and the second from 26 deaths per thousand live births in 1985-1990, to 21 in the period 1995-2000.[6] In contrast to these improvements, immunization coverage declined between 1996 and 1999, although there has been a recovery in 2000 and 2001. The drop in immunization rates has coincided with the appearance of controllable illnesses such as measles and whooping cough. This trend is associated with a variety of problems, in particular relating to funding for the extended immunization program (PAI).[7]

1.9 As regards transmissible diseases, malaria and dengue fever remain significant public health problems. Sexually transmitted diseases (STDs) are trending downwards, although their incidence is still above world averages. Rates of Hepatitis B and HIV infection have been rising strongly, especially among women. This trend reflects an increase in heterosexual transmission and implies greater risk of vertical or perinatal transmission.

1.10 Analysis shows that diseases of the circulatory system are the most frequent cause of death (125.6 per 100,000 deaths), followed by external causes resulting from the violence affecting society at large (105.1 per 100,000), malignant tumors (62.1 per 100,000) and transmissible diseases (30.0 per 100,000).

2. Health sector reform

1.11 Health-sector reform in Colombia has been one of the most ambitious attempts at social sector restructuring in the whole of Latin America. Implementation of the reform began with approval of Law 100 of 1993, which provides the main legal framework for the health sector reform process. The reform aimed to rectify situations of low coverage, poor quality, inefficiency and inequity resulting from a sector split into three different levels: (i) the strictly private system, which offered better quality services to a small proportion of the population in the highest income groups; (ii) the social security system covering employees in the formal sector (about 20% of the population) through services provided by the Social Insurance Institute (ISS) and other bodies; and (iii) the public system, funded from fiscal resources, which offered generally low-quality services to low-income population

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4 Maternal mortality in 1995: Estimates by WHO, UNICEF, UNFPA - WHO/RHR/01.9.

5 Pan American Health Organization, Report from the Ministry of Health transmitted to the Special Program for Health Analysis (SHA) by the PAHO/WHO Country Representative.

6 National Demographic and Health Survey, 2000.

7 Both the social reform program (1380/OC-CO), already disbursed, and the emergency social program (1455/OC-CO), currently being executed, include measures to protect immunization expenditure and set improved coverage targets.

groups and/or people not covered by social security through IPSs attached to the Ministry of Health.[8]

1.12 In view of this situation, the reform set three main objectives: (i) health insurance coverage for the entire population; (ii) more cost-efficient use of resources; and (iii) better quality healthcare. These objectives were to be achieved through a strategy of compulsory collective insurance, in conjunction with decentralization of healthcare supply, and an overhaul of the funding structure and management of public hospitals.

a. Insurance

1.13 The health insurance system in Colombia is established through the General System of Social Security for Health (SGSSS), defined by Law 100 of 1993. The SGSSS is funded from the compulsory insurance premiums paid by the population under the *contributory* and *subsidized regimes*.

1.14 The **contributory regime** is designed to cover wage-earners earning at least the minimum wage, and self-employed workers earning over twice the minimum wage with a compulsory health plan (POS). This system is financed entirely out of employer and employee contributions totaling 12% of earnings, of which the employer pays two thirds and the worker contributes the remainder. Workers and their families are insured through health promotion institutions (EPSs).[9]

1.15 To complement this system, the **subsidized regime** covers individuals who are unable to pay the quota in the contributory regime.[10] The subsidized regime has several sources of funding, including the transfer of 1% of workers' contributions in the contributory regime to the Solidarity and Guarantee Fund (FOSyGA), transfers from the national government to subnational entities through the general revenue-sharing system (SGP),[11] and any internally generated funds that departments or

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[8] In February 2003, the Ministry of Social Protection (MPS) was created by merging the portfolios of the former Health and Labor Ministries.

[9] The reform converts the ISS into an EPS and an IPS.

[10] The subsidized regime is open to persons classified in the poorest groups, i.e. levels I and II in the beneficiary selection system (SISBEN).

[11] The SGP represents the share of current income (revenues from VAT, income tax and levies on foreign trade) which the national government transfers to departments and municipios to finance health and education services.

municipios manage to contribute.[12] Subsidized regime management bodies (ARSs) were created to administer the subsidies.

1.16 The reform established a strategy of managed competition based on two competitive markets: insurance and health service provision. In the first of these, persons insured by the SGSSS are entitled to choose any insurer, public or private. This forces health management bodies (EPSs in the contributory regime and ARSs in the subsidized regime) to compete for affiliates on the basis of the quality of the services they are able to offer. The insurers receive a capitation grant (UPC) per affiliate, which is fixed and paid by the government, in exchange for guaranteed provision of a compulsory health service package (POS) to affiliates. In the second market, health service providers compete by selling services to insurers, and these in turn procure health services on behalf of their affiliates, selecting and negotiating the best possible price-quality combination among suppliers, both public and private.

1.17 The State acts as regulator and director of the system and establishes the basic operating rules. The reform aims to have 100% of the population insured by 2001, and provides that while total coverage is being achieved, uninsured persons from low-income population groups will be given preferential care by public hospitals. Increased insurance coverage has been the reform's main achievement (Table I-2): between 1992 and 2001, the system grew significantly from 8.9 million to 24 million affiliates.

[12] Sources of funding for the FOSyGA include the following among others: (i) 1% of the solidarity contribution from the contributory regime; (ii) between 5% and 10% of resources from the Cajas de Compensación [family benefit funds]; (iii) the State contribution (a minimum of 25% of revenue collected in (i)); (iv) financial returns earned from the investment of FOSyGA funds; (v) a percentage of operating revenues obtained from the Cuisiana and Cupiagua oil wells; and (vi) a tax on armaments and munitions, among others. Apart from its use as a health insurance fund (contributory and subsidized), FOSyGA also finances healthcare for catastrophic illnesses and traffic accidents, in addition to promotion and prevention programs.

Table I-2 Health insurance coverage, 1992-2001

Population	1992[1]	1995	1996	1997	1998	1999	2000	2001
Total[2]	32,113,615	38,541,631	39,295,798	40,064,093	40,772,994	41,539,011	42,299,301	43,035,394
Affiliates of subsidized regime[3]	0	4,800,916	5,981,774	7,026,690	8,527,061	9,325,832	9,510,560	11,062,708
Affiliates of contributory regime[4,5]	8,964,816	n.a.	13,728,297	14,969,278	11,860,174	13,003,597	13,063,046	13,077,930
Unaffiliated	23,148,799	n.a.	19,585,727	18,068,125	20,385,759	19,209,582	19,725,695	18,630,280
Not covered[4] (%)	72.00	n.a.	49.80	45.10	50.00	46.00	47.00	48.00
Coverage (%)	28.00	n.a.	50.20	54.90	50.00	54.00	53.00	52.00
Coverage quintile[1] (%)	4.20	n.a.	n.a.	43.10[6]	n.a.	n.a.	35.02[7]	n.a.
Coverage quintile[5] (%)	55.40	n.a.	n.a.	78.70[6]	n.a.	n.a.	74.75[7]	n.a.

n.a.: data not available

1. Source: Vélez C.E., "Gasto social y desigualdad". DNP-Misión Social, page 164.
2. Source: DANE.
3. Source: Ministry of Health.
4. Excludes population groups affiliated to special regimes (armed forces, teachers, universities, Ecopetrol and others).
5. Source: Ministry of Health.
6. Source: ECV-1997. Calculations DNP-DDS-SS.
7. Source: EH-107-2000. Calculations DNP-DDS-S.

1.18 Expansion of benefits to cover the family group and access to the subsidized regime were the key factors behind the expansion of affiliation. The most significant progress was made in equity terms, with the poorest 20% of the population expanding their coverage from 4.2% to 43.1%. After 1998, however, the coverage level declined for several reasons, including: (i) a drop in the number of contributory affiliates in the wake of the economic crisis; and a reduction in revenue collected from the contributory regime, which also affected solidarity funding for its subsidized counterpart; (ii) failure to include all funds available in the FOSyGA solidarity subaccount in the general national budget, because of fiscal constraints arising from the economic recession; (iii) the move from supply to demand subsidies is still incomplete, partly because of growing and inefficient hospital expenditure; and (iv) evasion and avoidance of contributing to the system.

1.19 Nonetheless, the existence of over 18 million uninsured Colombians, half of whom are poor, has put extraordinary pressure on public hospitals, which are mandated to provide healthcare to low-income people not affiliated to the SGSSS.

b. Decentralization

1.20 The process of decentralization and transfer of resources and competencies from the national level towards municipios and departments was initiated under Decree Law 77 of 1987, Law 10 of 1990 and the 1991 Constitution; and it was subsequently consolidated in Law 60 of 1993 (the Decentralization of Resources and Functions Act), and amended by Law 715 of 2001. The decentralization process has enabled subnational bodies to assume greater responsibilities in public health management and the payment of subsidies to people living in poverty. Law 60 of 1993, in particular, gave the departments basic responsibility for financing and guaranteeing

the provision of second- and third-tier health services, while making municipios responsible for the first tier. Management and regulatory functions at the national level are assigned to the Ministry of Health and to the National Council for Social Security (Law 100 of 1993).

1.21 At the subnational level, health services are funded by a portion of the transfers made from the national budget to subnational authorities under the general revenue-sharing system (SGP), together with earmarked revenues—the proceeds of taxes levied directly by the departments that are specifically destined for health, such as taxes on lotteries, spirits and beers.

1.22 The decentralization process has generated significant growth of public spending on healthcare, such that aggregate expenditure by the national, municipal and departmental levels combined rose from 1.1% of GDP in 1987 to 5% in 2001. Making use of these additional funds, subnational bodies have expanded health service supply at the municipal and departmental levels in a haphazard fashion, with duplications arising from the creation or expansion of institutions or services without considering demand requirements or installed capacity, either public or private.

1.23 A study carried out by the Health Ministry[13] shows that the number of health-sector workers grew from 86,000 in 1994 to 105,235 in 1997—a relative increase of 21%. Distinguishing between professional categories, the highest levels of employment among healthcare staff were registered by dentists (52%), followed by medical doctors (47%). Employment in the auxiliary administrative staff category grew faster (73%) than among healthcare workers.

c. Public hospitals

1.24 According to the 2000 household survey (EH-2000),[14] public hospitals account for two thirds of all hospitalizations in Colombia. Accordingly, service quality and expenditure efficiency in these hospitals are crucial issues for the health sector. In terms of human and technological resources used, public hospitals are divided into three levels of care: (i) the first tier corresponding to local hospitals that provide basic care; (ii) the second level which includes local or regional hospitals providing specialized care; and (iii) the third level which consists of benchmark hospitals endowed with high levels of medical technology. Table I-3 displays a number of key indicators of public hospitals by level of care.

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[13] Censo del Recurso Humano y la Dinámica Salarial entre 1994-1998 [Census of Human Resources and Wage Dynamics 1994-1998].

[14] Ministry of Health, Analysis of household survey contracted with Econometría, Bitrán Asociados, and ESAP. Bogotá, 2001, pp. 52 - 53.

Table I-3. Public hospital indicators (2002)

Level of Care	Number of institutions	Number of beds	Number of patients released	Occupancy rate %
Level 3	24	5,894	339,466	86.07
Level 2 with 80 beds or more	35	4,077	316,230	75.06
Level 2 with less than 80 beds	82	4,030	305,887	61.73
Level 2 psychiatric	9	1,343	15,510	89.32
Level 1 with beds	550	14,753	509,302	24.54
Level 1 with no beds	220	n.a.	n.a.	n.a.
TOTAL	920	30,052	2,972,790	51.3

1.25 The reform process has made changes to public hospital funding and management mechanisms. Law 100/1993 required them to become **State social enterprises (ESEs)**—decentralized public bodies with their own legal status, capital and administrative autonomy—and they have also had to support themselves by charging for their services.

1.26 This has implied changes in their financial system. The creation of ARSs and EPSs has meant implementing a system for the purchase and sale of services with these entities, which ought to improve hospital productivity, efficiency and quality. The result is that public hospitals now receive operating funds through three channels: (i) transfers or supply subsidies in the traditional form; (ii) contracts between sectional and local funds to provide healthcare to affiliates in proportion to invoicing; and (iii) contracts with ARSs and other system purchasers for the sale of services.

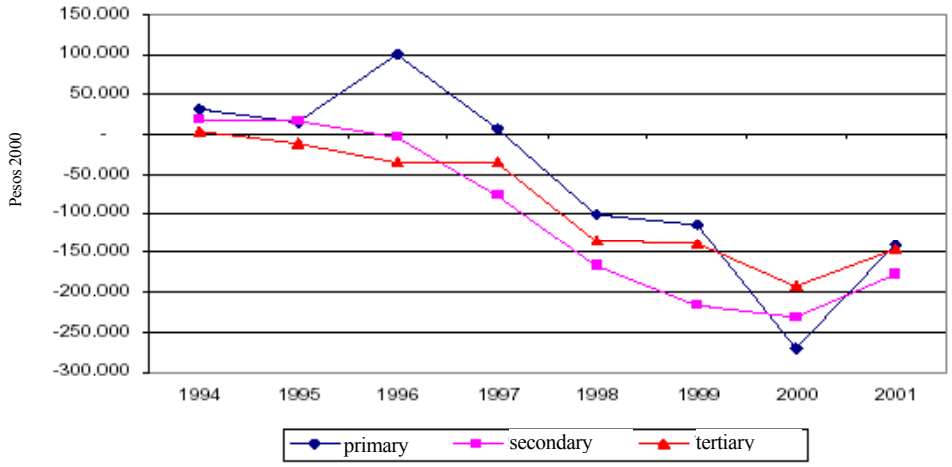
1.27 The change has posed a major challenge for public hospitals. Since 1993, they have had to operate as if they were private firms, learning to market their services, make contracts and send out invoices. The most significant aspects of this process include the establishment of boards of directors, with participation shared equally between the political-administrative, technical-scientific and community sectors. In addition to appointing "managers" for fixed-term contracts, subject to fulfillment of education and experience requirements, the aim was to provide autonomy and a higher technical level for enterprise decision-making processes. From the functional standpoint, the institutions were forced to implement or improve managerial, administrative and financial processes, many of which were nonexistent before the reform.

3. The crisis in public hospitals

1.28 Despite this legal framework, most public hospitals have been unable to achieve an adequate level of self-financing. As income growth has faltered because of the stalled expansion of insurance, and costs have been rising because of structural and internal management problems, the national government has had to transfer funds from FOSyGA and other sources to cover the deficit generated by public hospitals.

1.29 From the financial standpoint, third and second-tier hospitals began to register deficits in 1995 and 1996, respectively. First-tier hospitals have posted deficits since 1997, at a level exceeding those of second- and third-tier hospitals in 2000 (see Figure I-1).

Figure I-1. Annual operating deficit of public hospitals



1.30 According to Health Ministry data, hospitals had accumulated debts of 1,015,074 million pesos (US$352 million) as of 31 May 2001. This increase in liabilities not only affects the financial viability of public hospitals themselves but has also delayed the changeover in subsidies, limited the expansion of coverage of the subsidized regime, and become the main cause of the cumulative deficit of the subnational non-financial public sector.[15] Given that payroll expenses account on average for 66% of the recurrent costs of a second- or third-tier hospital, it is hardly surprising that the main liabilities accumulated by hospitals are payroll-related (about 51% of the total)—debts arising from the non-payment of wages and benefits, in addition to pensions and unemployment subsidies. The remaining debts corresponded to amounts owed to suppliers (26%), financial debts (7%), and others (16%).[16]

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[15] According to Banco de la República, "the deficit accumulated by the subnational non-financial public sector in 2001 is largely explained by the results of the decentralized bodies, particularly departmental ones, which recorded the highest expenditure levels. These levels of government generated a deficit of 656.5 million pesos between them." Public hospitals registered the largest financial shortfalls, accounting for about 90% of the total subnational deficit. Banco de la República. Subgerencia de Estudios Económicos – Dirección de Finanzas Públicas, June 2002.

[16] CONPES document 3204. National Planning Department, page 12.

1.31 Looking to the future, in the absence of the proposed restructuring program, the financial deficits of public hospitals are likely to grow. It is estimated that if current operating conditions are maintained, the cumulative deficit for 2002-2006 would probably reach US$750 million, equivalent to 0.62% of GDP in the latter year[17] (see paragraph 4.5).

1.32 There are many explanations for this phenomenon. **Structural problems within the hospitals** include: (i) a management and health service supply structure that is overblown in terms of physical and human resources, compared to the real demand for services; and (ii) high production costs stemming from "sinecure" posts, compounded by high wage and benefit burdens. These problems mainly arose during the first few years of reform implementation, when subnational bodies expanded the supply of health services at the municipal and departmental levels without taking care to avoid duplication, and awarded wage increases above the public-sector average (see paragraphs 1.22 to 1.23).

1.33 In addition to these considerations, there are **domestic factors relating to hospital management**: (i) inadequate implementation of management processes for planning, organization, oversight and business decision-making; (ii) inadequate contracting processes for the sale of services and low invoicing levels; and (iii) inadequate implementation of financial and managerial information systems. These factors arise from the failure of most public hospitals to match their legal transformation into ESEs with the corresponding managerial and functional adjustments.

1.34 There are also **external factors** that have made it harder for public hospitals to achieve self-sustainability: (i) labor laws require severance payments to be made that exceed their financial capacity; (ii) the human resource cost of public hospitals is at least 36% higher than the corresponding cost in the private regime; (iii) the uninsured population continually demands health services from the public network; (iv) the DTSs display a weak level of development, with little capacity to direct, organize, oversee and control the behavior of the stakeholders involved; (v) the current political and financial incentives regime affects how funds are allocated for serving the poor, uninsured population; there are no accountability mechanisms; and management of the institutions is driven by politics; and (vi) development of the SGSSS information system is deficient.

1.35 Thus, the hospital crisis is unsustainable both financially and socially. Burgeoning liabilities are causing health services to be suspended owing to a lack of inputs and essential materials. This situation is particularly serious given the importance of public hospitals for the Colombian health system, and especially their role as healthcare suppliers to poor people who are not affiliated to the SGSSS or belong to

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[17] Op cit page 15.

the subsidized regime, since they provide coverage in remote areas that other suppliers do not reach.

C. The country's strategy in the health sector

1.36 To solve some of the main conceptual and regulatory problems faced by the reform process, in December 2001 the Government of Colombia sent Law 715 to Congress in order to reformulate Law 60 of 1993. The new legislation which was approved: (i) defines a clear separation of competencies between departments and municipios; (ii) makes health funding independent of other municipal funds; (iii) defines health strategies more flexibly, allowing for adaptation to the different subnational realities; and (iv) defines the department as the government level responsible for organization, direction, coordination and management of the public health services network. With the clear objective of putting an end to duplication in health service provision, the new law does not allow municipios to accept responsibility for new services or expand existing ones; and it obliges them to coordinate with the departmental network.

1.37 In the 2003-2006 National Development Plan (Law 812 of 2003), the government has made a commitment to extend health insurance to 5 million new affiliates before 2006, which will account for 28% of the population uninsured in 2003. This extension will be based on the gains expected from the proposed program, and from other reforms that have been supported through different sectoral programs (1480/OC-CO, 1380/OC-CO).

1.38 The National Development Plan also underscores the need to achieve operational restructuring in public hospitals, improve quality and decision-making capacity at the least complex level, and implement mechanisms to integrate primary, outpatient and hospital care services in the public networks. For this purpose: (i) it will implement a care model in which service networks are established at the departmental level; and (ii) the national government and subnational bodies will work together, under the forgivable loan modality, to finance the process of public hospital adjustment and restructuring, through performance contracts signed with the subnational entities and the hospitals.[18]

1.39 In developing the above, in November 2002 the National Economic and Social Policy Council (CONPES) issued document 3204, laying down guidelines on service provision policy for the SGSSS, and giving priority to the public hospital modernization process when allocating funding from the general national budget. This will help to: (i) reduce the negative impact of hospital expenditure on the subnational fiscal deficit; (ii) improve the market performance of public hospitals

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[18] Article 54, third paragraph, of Law 715 of 2001, empowers the national government to extend forgivable loans to subnational entities in order to promote the public hospital adjustment program.

under conditions of efficiency, efficacy and quality; and (iii) promote a steady expansion of health insurance coverage for the country's low-income population.

D. The Bank's strategies

1. The Bank's strategy with the country

1.40 The Bank's strategy with the country (document GN-2267-1) establishes three fundamental areas in which actions are defined for the period 2003-2006: (i) laying foundations for reviving and energizing the economy; (ii) promoting social development and protecting the most vulnerable; and (iii) improving governance in Colombia and supporting the State reform process. The country strategy also identifies two major constraints: expansion of the fiscal deficit and escalation of the civil conflict. The first of these is a constraint that needs to be resolved in the short-term if any development strategy is to be viable.

1.41 In terms of the fundamental areas of the country strategy, the operation will mainly contribute to objective (ii). Firstly, support for the move from supply to demand subsidies will make it possible to extend health insurance coverage in the subsidized regime to the poorest population groups. Secondly, progress in the public hospital modernization process will contribute to a financially sustainable social service provision that is more effective in meeting the population's needs and more efficient in resource use. Protection of human capital investment, by improving health conditions, raises the economy's growth potential, thereby supporting objective (i). In addition, reorganization, redesign and modernization among health service suppliers should promote State efficiency and improve governance, thereby supporting objective (iii).

1.42 The country strategy also establishes indicators and targets that are directly related to the proposed operation. Specifically, it establishes the following targets in the priority area to *promote social development and ensure protection for the most vulnerable*: (i) increase the number of financially viable hospital networks providing an efficient service from 21 in 2002 to 54 by 2005; (ii) expand coverage of the subsidized regime by 44.2%, from 11.3 million in 2001 to 16.3 million by 2006; and (iii) reduce the mortality rate among children under five years of age from 23 per thousand in 2000 to18 per thousand by 2006.

2. The Bank's strategy in the social sector

1.43 The Bank's Social Development Strategy (document GN-2241-1) proposes four action areas to help countries speed up social progress: (i) target reforms in health, education and housing to the population's specific needs; (ii) implement a human development program encompassing the whole life cycle; (iii) promote social inclusion and prevent social evils; and (iv) provide comprehensive services with subnational targeting.

1.44 This operation will mainly contribute to the first SDS objective, by supporting a health reform process that aims to extend the coverage of health insurance and promote efficiency in the use of public funds allocated to the sector.

E. The Bank's experience and lessons learned

1.45 Projects financed by the Bank, such as health service improvement (716/OC-CO) and the health sector reform support program (910/OC-CO), have played a major role in fine-tuning instruments and policies for implementing reform in the sector, and this program is the direct outcome of experience gained in these two loans.

1.46 The health services improvement program, whose main target population was public hospitals of medium and high complexity, initially proposed to modify management conditions in the target institutions, but not structural ones. The main lines of action of the reform support program already recognized the need for a comprehensive program of institutional support and change in public hospitals, including radical restructuring of staffing and service production, in order to reduce operating inefficiencies and deliver the services that are actually needed at grass-roots level. These recommendations were based on the definition of a hospital restructuring pilot project.

1.47 This operation is also supported by policy measures introduced under sectoral loans approved in earlier years, including: (i) support for rationalization of subnational transfers in the health sector (Law 715); (ii) extension of the subsidized regime; (iii) implementation of a quality control system; (iv) reduction of administrative processing times in transferring resources in the SGSSS, particularly in the subsidized regime; (v) protection of public health expenditure; and (vi) restructuring of the ISS, among other things.

1.48 The health and social security reform program (1480/OC-CO) warrants special attention because it establishes the necessary conditions within the SGSSS to afford sustainability to the adjustments made under this program: it continues to contribute to the expansion of the subsidized regime, which is a key element in reducing supply subsidies; it establishes guidelines for savings to be made through hospital modernization at the national level; and it makes reforms in other SGSSS institutions and processes in order to release funds for the expansion of insurance coverage. The program includes conditions in its policy matrix aimed at supporting this process through time. In particular, the first tranche of the operation requires evidence to be presented of having signed agreements and a plan for public hospital restructuring; while the second tranche requires evidence that these are being fulfilled. In addition, the operation promotes the switch from supply subsidies to demand subsidies, requiring subnational bodies to meet targets for extending insurance coverage in the subsidized health regime, and implementation of rules defining the policy for reducing the supply subsidy. In this regard, the health and social security reform program reinforces the restructuring to be part-financed by this program, by providing incentives for effective operational reorganization of

public hospitals, and ensuring that resources and savings produced for the hospital reorganization process are used to extend insurance in the subsidized health regime.

1.49 A technical cooperation project being funded by the Japan Special Fund (ATN/JO-7650-CO) is supporting preparation of this operation, by implementing some of the new proposals for institutional modernization and operation in heterogeneous networks. This exercise has also served to validate the instruments that will be used in implementing the proposed operation.

1.50 Lastly, there is a technical cooperation project being financed by the United Kingdom Fund for Consultants (ATN/KC-8497-CO), which is providing technical assistance to the MPS in defining new public-private schemes of participation in the funding and management of public hospitals.

1.51 Table I-4 summarizes Bank support for the health sector in Colombia:

Table I-4. Summary of Bank support in the health sector

Name	Activities or conditions	Results achieved	Lessons learned
Health services improvement program (716/OC-CO) *Completed*	Strengthening of public hospital management before and during the reform. Pilot project for reorganization and strengthening of management in a sample of public hospitals, cofinanced with funds from the national health sector reform support program.	Contribution to hospital sustainability by turning hospitals into ESEs; implementation therein of managerial and administrative processes that were unknown prior to the reform; and support for the process of converting supply subsidies into demand subsidies. Significant improvement in the efficiency of health service production in the hospitals intervened in the pilot project.	Except in the pilot project, the program did not alter structural conditions in public hospitals, which affected the program's chances of success in its original design.
Health sector reform support program (910/OC-CO) *In execution*	Studies and actions carried out to help achieve the objectives of implementing the social security for health system, in terms of universal coverage, equal access, institutional efficiency and service quality. Cofinancing of the pilot reorganization project and management strengthening in a sample of public hospitals.	The studies financed have focused on key issues in reform of the sector, and their results have been built into sectoral legislation on policies, institutions and human resources. The program also contributed financing for the pilot hospital reorganization project, which produced a significant improvement in the efficiency of health service production in the participating hospitals.	Project implementation has been affected by the pace of progress of reform in the sector, since the two are closely linked.

Name	Activities or conditions	Results achieved	Lessons learned
Subnational fiscal reform program (1265/OC-CO) *Completed*	Modification of transfer formulas to subnational health service bodies. Definition of competencies between the national government and subnational health service entities. Organization and restructuring of subnational pension liabilities. Binding constraints placed on transfers outside the SGP.	Growth of transfers controlled. Regulatory basis for defining competencies established. Foundations laid for starting to restructure the subnational liability.	Although substantial progress was made in subnational fiscal restructuring, legislative timeframes mean that the detailed regulations underpinning the reforms will need further development in subsequent operations. Moreover, support for continuing adjustment processes following legal reform is crucial.
Social reform program (1380/OC-CO) *Completed*	Extension of the subsidized regime. Regulation and progress in applying partial subsidies at the subnational level to insure low-income workers with some contribution capacity. Protected expenditure and immunization targets for 2002.	Subsidized regime expanded by 300,000 people. Regulation approved, little impact on extension of insurance coverage. Expenditure executed as agreed, average immunization rate for selected diseases rises from 77% in 1999 to 82.6% in 2002.	A PBL could help achieve coverage targets in key health programs. Fiscal constraints at the subnational level, compounded by the structural problem of hospitals, made it impossible to extend insurance beyond the target set by the program.
Social emergency program (1455/OC-CO) *In execution*	Protected expenditure and immunization targets for 2003. Regulation and targets for introducing a quality control system in the SGSSS. Regulation and targets for reducing processing times between the ARS and suppliers in the subsidized regime.	Allocation and execution of expenses as agreed. Coverage targets to be reported at the end of 2003. 23 IPS, EPS and ARS in process of accreditation under the new system. Reduction of processing time between charging and cash payment in the SGSSS from 167 days to 110.	Emergency operations are effective instruments for ensuring the continuity of ongoing reforms in the social sector during periods of fiscal constraint, including in the health sector.
Health and social security reform program (1480/OC-CO) *In execution*	Public hospital restructuring plan to generate an average saving of 20% in the restructured institutions. Review of POS-UPC in order to ensure financial balance. Reduction of evasion and avoidance levels in the SGSSS. Restructuring of the ISS in order to fully implement Law 100.	Instruments designed and relevant laws approved; impact results to be reported by the second tranche.	Recently approved (October 2003).

Name	Activities or conditions	Results achieved	Lessons learned
	Implementation of a regime of transparency and competitiveness among Family Benefit Funds.		

1. Lessons learned from the pilot project

1.52 In late 1999 the Government of Colombia requested Bank support for the recovery of hospitals in the most critical situations. Approximately US$75 million[19] was allocated to the pilot project for staff downsizing, reorganization and technical assistance in 26 public hospitals at the second and third levels. The results and lessons learned from this exercise served as inputs in preparing this new operation.

1.53 Bank funds allocated to the pilot project were used entirely for making severance payments to workers laid-off in order to adapt staffing to the demand for services, reduce costs and bring income and expenditure into balance. Pilot project actions were coordinated with those being implemented in the health services improvement program aimed at improving hospital managerial capacity. The results achieved were positive: (i) total hospital staffing was cut by about 31%, with more administrative than care-giving jobs eliminated (46% compared to 24%, respectively); (ii) the number of underused beds was reduced; (iii) the number of days for which patients were kept in the hospital was cut; and (iv) the number of urgent surgical procedures and consultations increased, while activities pertaining to other levels of care, such as normal childbirth and external consultations, declined. In general, hospitals that have fulfilled the commitments agreed to in the performance contracts have stabilized their operations in terms of service provision, alleviated situations of financial distress and labor conflict, and reduced expenditure to a sustainable level, while maintaining or increasing the production and quality of services.[20] From the period of intervention to 2002, the hospitals that participated in the pilot project broke even.

1.54 The pilot project also demonstrated the political feasibility of carrying out this type of reform. The reforms were well received by ESE employees, since wage arrears could be paid in full. In addition the ESEs took steps to help laid-off workers re-enter with the labor market. By improving productivity and the quality of services provided, user satisfaction levels also increased.

1.55 Another of the important lessons gained from the pilot project is that, given the close relationship and interdependence that exists between the three care levels,

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[19] US$30 million was obtained by reassigning existing credits (716/OC-CO and 910/OC-CO), and funds equivalent to US$45 million were provided by the Colombian government.

[20] Performance of hospitals at the secondary and tertiary care levels restructured in 1999. Ministry of Social Protection, Bogotá, 2002.

recovery that is sustainable in the long run needs to involve all the organizations that participate in public supply of services in a given population area, in conjunction with subnational direction, coordination, supervision, and oversight mechanisms. In particular, the pilot project revealed that network design should have the following objectives: (i) improvement of access and timeliness of health service supply; (ii) optimization of installed capacity, hospital staff, the portfolio of services provided, technology and financial resources according to demand requirements; and (iii) development and implementation of referral and counter-referral systems, in order to optimize capacity to achieve healthcare outcomes, especially among low-complexity institutions.

F. Coordination with other multilateral development agencies

1.56 The effort to support Colombia in both reform implementation and funding is being coordinated between multilateral agencies and the Government of Colombia. Under sectoral support, the IDB and the World Bank are working together to protect expenditure aimed at financing an extension of the subsidized regime. Although the World Bank does not currently have operations in the health sector, the project team has exchanged information with it in order to coordinate the policy dialogue in the sector.

1.57 The IMF standby arrangement also serves as a frame of reference for commitments by multilateral agencies covering US$7.349 billion of approvals for the period 2003-2006. Of this amount, approximately US$2.649 billion is expected to consist of investment loans.

II. THE PROGRAM

A. Objectives

2.1 The main objective of this program is to support changes in public hospital management by raising the efficiency and quality of service provision. This will help to make public health service networks technically and financially viable, and allow for an expansion of insurance coverage within the SGSSS framework.

2.2 The program's specific objectives are: (i) to enhance the efficiency and quality of public hospital health services in a context of medium-term financial sustainability, under the managed competition framework established by the health reform. This will involve actions to assist IPSs, DTSs and the MPS; functional integration of IPSs in health service networks; implementation of human resource rationalization measures, and modification of the incentives regime in operational funding linked to output and quality targets; and (ii) implementation of a system to monitor and evaluate the performance of health service supply networks.

B. Conceptualization of the program

2.3 Since Law 100 was passed in 1993, the country has steadily expanded health insurance coverage; and, despite the stagnation of recent years, affiliation to the subsidized regime has grown to over 11 million Colombians from low-income sectors. Nonetheless, the health reform did not meet the target of universal coverage, and over 9 million people remain uninsured.

2.4 The reasons for this stem from the fact that expenditure levels in public hospitals have outgrown their capacity to finance them through the sale of their services. In brief, the system today is trapped in a vicious circle: insurance coverage is stalled because large sums are being used to subsidize supply; and supply subsidies are kept on because the slow growth of insurance makes them essential. Furthermore, in recent years a significant proportion of additional financing, including funds from the FOSyGA solidarity subaccount, have been used to cover the public hospital financing deficit. Moreover, perverse incentives have been created by making additions to the general national budget in order to cover burgeoning hospital costs year by year.

2.5 The program intends to break this vicious circle by resolving the multiple factors that underlie the public hospital deficit (see paragraphs 1.32 through 1.34). In particular, it aims to: (i) solve internal structural problems stemming from a bloated structure of management and health service provision, by financing and implementing the necessary adjustment processes under the forgivable loan modality; (ii) overcome management weaknesses in public hospitals through technical assistance activities aimed at public IPSs; (iii) solve some of the external factors by developing the capacity to direct, organize, oversee and supervise the

DTSs, supporting the healthcare model based on service networks; and (iv) modify the current financial incentives regime to more efficiently allocate funds for serving the poor, uninsured population and establish management accountability mechanisms.

C. Structure of the program

2.6 The program contains two components: (i) operational reorganization of public hospital networks through performance contracts signed between the national government and subnational bodies (DTSs); and (ii) monitoring and evaluation. The first component supports the sector at the subnational level (departments and municipios), as well as the IPSs, through technical assistance activities, information systems development and rationalization of human resources. The second component will finance technical assistance activities and development information systems in the sectoral governing body (MPS), for monitoring, oversight and evaluation of the policy on health service provision and the modernization program, in particular. It is estimated that the program will cover approximately 132 public IPSs, about 20% of the national total.[21]

1. Component 1: Operational reorganization of public hospital networks (US$80.768 billion)

2.7 This component encompasses activities related to operational reorganization and technical assistance for hospitals and DTSs. The instruments that group these activities together are performance contracts between the national government and the subnational body, linked to credits that are potentially forgivable provided the specified performance targets are met. The contracts will be signed between the national government, subnational bodies and the IPSs.[22] The component will fund technical assistance and operational reorganization activities for an estimated 132 public IPSs in 20 to 30 DTSs.

a. Technical assistance for the DTSs

2.8 The purpose of this subcomponent is to provide technical assistance to the DTSs in their role as mechanisms responsible for the organization, direction, coordination and management of hospital networks. The aim is to ensure an effective process of operational restructuring among IPSs in networks guaranteeing efficient delivery of health services to the public.

2.9 In order to improve the organization and management of hospital networks, the program will support DTSs in: (a) organization, direction and management of health service supply networks; (b) development and implementation of referral and

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[21] This operation is not expected to solve all hospital problems in Colombia, but the country is committed to continuing the actions over the medium-term.

[22] Chapter III gives details of performance contracts, loan agreements and component execution.

counter-referral systems; (c) implementation of processes for evaluation, monitoring and oversight of the work of public IPSs; (d) development and implementation of manuals and guidelines for supervision and oversight of network operation; (e) modification of existing financial incentives for more efficient allocation of resources to care for the poor, uninsured population, and establishment of management accountability mechanisms; (f) use of direct transfers in the situations expressly authorized by law;[23] (g) evaluation and application of private participation alternatives in IPS management; (h) development and implementation of manuals and guidelines on protection of the occupational health of workers in the sector and management of hospital waste; and (i) development and implementation of service integration agreements—both functional and structural—between the different IPSs in the network.

2.10 In addition, funding will be provided to design labor retraining schemes for workers whose jobs are eliminated in the course of the program. Training courses would be implemented by the IPSs, within the context of Law 443 of 2002, which makes it compulsory for the entity to provide training for workers who are made redundant. The MPS will support these processes by coordinating the necessary technical assistance. The program will also finance development and implementation of manuals and guidelines for sociocultural and environmental adaptation, in order to improve healthcare and access to health services among indigenous and Afro-descendent population groups within the SGSSS.

2.11 To carry out these activities, this subcomponent will fund: (i) technical assistance; (ii) training; and (iii) computer hardware, software and networks.

b. Technical assistance for the IPSs

2.12 This subcomponent will finance technical assistance to improve IPS financial management: (i) improvements in managerial processes, particularly those relating to scheduling and oversight of service production, enabling institutions to operate in coordinated networks; (ii) establishment and/or improvement of administrative, financial and cost management processes; and (iii) design and implementation of outsourcing of supplementary services in the IPSs.

2.13 Actions will also be supported to make service delivery more efficient: (i) identification of the service portfolios in each IPS, to guarantee integrity and continuity of services under criteria aimed at rationalizing human, physical and financial resources; (ii) definition and implementation of monitoring systems based on targets for production, productivity, care quality and cost rationalization; (iii) provision and implementation of management tools and integrated information, assistance, administrative and financial systems; (iv) development of care

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[23] Law 812 of 2003 restricts the application of direct transfers to the purpose of guaranteeing service provision where market conditions are monopolistic and service providers are not financially sustainable under efficient conditions.

guidelines and continuous education actions for staff providing less complex services, in order to improve their capacity to achieve healthcare outcomes; and (v) actions aimed at complying with regulations on the disposal of hospital waste. To strengthen IPS capacity, funding will be provided for technical assistance and training, and for computer hardware, software and networks.

c. IPS operational reorganization

2.14 This subcomponent will support IPS operational reorganization in order to adapt the staffing structure. The program will finance the corresponding severance payments, obligations, and settlements arising from downsizing and rationalization in IPSs participating in the networks.[24] The selection of employees to be laid off will be made bearing in mind the service portfolio in each IPS, the services to be discontinued or reduced, and those that will continue operating. Based on this criterion, up to two potential lay-off categories will be identified: (i) employees subject to compulsory redundancy because their jobs are eliminated; (ii) employees who accept voluntary redundancy because the number of jobs in their category is cut. This process would not include the disabled and workers with three years or less before normal retirement. It is estimated that 9,670 employees will be eligible for severance payments at an average cost of US$6,520 per person, for a total of up to US$58 million from the Bank's financing.[25]

2. Component 2. Monitoring and evaluation (US$3.253 billion)

a. Monitoring and evaluation of the policy on health service provision

2.15 This subcomponent will finance activities to enhance MPS capacity to implement, monitor and evaluate policy on health service provision.

2.16 The activities to be funded are as follows: (i) technical assistance; (ii) training activities; and (iii) computer hardware, software and networks.

b. Program monitoring, oversight and evaluation

2.17 This subcomponent will support the following activities: (i) monitoring and oversight of program execution in establishing and operating the networks; (ii) baseline creation; and (iii) midterm review and final evaluation of the program to measure impacts on cost reduction, improvements in service provision and fulfillment of production and quality targets.

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[24] The program will not fund labor-market liabilities of any kind for current staff.

[25] The size of individual severance payments depends on the worker's job category (free appointment, administrative career or official worker), in addition to his or her wage history and years of service.

2.18 To carry out these activities, this subcomponent will fund the following: (i) technical assistance; and (ii) computer hardware, software and networks.

3. Program management (US$1.195 billion)

2.19 This component will support the hiring of the technical-administrative staff required for the program coordination unit (PCU), the financial management costs, in addition to costs associated with financing the program's external audit.

D. Cost and financing

2.20 The total cost of the operation will be US$90 million, of which US$72 million will be financed by the Bank, and the remaining US$18 million will be covered by local counterpart funding. The program will last for four years. Table II-1 sets out the costs and funding sources for each component.

Table II-1. Program costs and funding sources
(thousands of US dollars)

Components	Source		Total	% of total
	Financing	Local contribution		
1. Reorganization of IPS networks	**66,029**	**14,739**	**80,768**	**89.7**
Technical assistance for DTSs	2,002	1,614	3,616	4.0
Technical assistance for IPSs	5,981	8,078	14,059	15.6
Operational reorganization of IPSs	58,046	5,047	63,093	70.1
2. Monitoring and evaluation	**2,027**	**1,226**	**3,253**	**3.6**
Monitoring and evaluation of the policy on health service provision	826	893	1,719	1.9
Program monitoring, oversight and evaluation	1,201	333	1,534	1.7
3. Program management	**263**	**932**	**1,195**	**1.3**
Coordination unit	0	463	463	0.5
Financial management costs	0	357	357	0.4
Audit services	263	112	375	0.4
SUBTOTAL	**68,319**	**16,897**	**85,216**	**94.7**
4. Contingencies	**3,681**	**774**	**4,455**	**5.0%**
5. Loan supervision	**0**	**0**	**0**	**0.0%**
6. Credit fee	**0**	**329**	**329**	**0.4%**
TOTAL PROJECT COST	**72,000**	**18,000**	**90,000**	**100**
% by source	80%	20%	100%	

III. PROGRAM EXECUTION

A. Borrower and executing agency

3.1 The borrower in this operation will be the Republic of Colombia. The Ministry of Social Protection (MPS) will serve as executing agency, acting through the program coordination unit (PCU), which in turn will be accountable to the MPS General Service Quality Directorate. The PCU will be responsible for coordination, management, supervision, guarantee of execution and correct use of program resources, as detailed in the program's Operating Regulations.

3.2 Other entities participating in the program will be the Ministry of Finance and Public Credit (MHCP), subnational entities (departments, districts and municipios, when the network to be intervened includes municipal or district institutions), the DTSs, and the IPSs themselves.

3.3 This execution modality was chosen because of the success of the pilot public hospital restructuring project, and the need to ensure coherence and governance in the sector and consistency with the subnational fiscal adjustment process.

B. Program execution and management

3.4 **Program sequencing.** Given the availability of program funds, thanks to the budget assigned to it by the national government, about 132 hospitals[26] and at least 20 DTSs are expected to be covered in the period 2004-2007, as follows:

Care level	2004	2005	2006	2007	Total
Level 1	5	5	8	29	47
Level 2	14	16	26	22	78
Level 3	3	2	1	1	7
Total	**22**	**23**	**35**	**52**	**132**

3.5 **Prerequisites for program participation by subnational bodies and IPSs.** To be eligible to participate in the program, subnational bodies and IPSs need to formally express their intention to participate and prepare diagnostic studies of health service provision within their jurisdiction, together with a network organization proposal and a plan for reorganizing their IPSs. These diagnostic studies will be prepared for

[26] The total number of institutions expected to receive intervention each year using project funding may vary, depending on the care level of the institutions included and the amount of funding needed to carry out actions in the operational reorganization component.

each DTS, with technical assistance and guidance from the MPS. A diagnostic study template is included in the program's Operating Regulations. With DNP assistance, and bearing in mind the fiscal analysis of each subnational body provided by the MHCP, the MPS will evaluate the diagnostic studies prepared by each DTS and then target and prioritize the bids submitted, in order to distribute the program funds allocated in component 1.

3.6 **Targeting and prioritization of subnational entities.** Bids will be selected in a two-stage process. The first step will consist of targeting, to give greater weight to IPSs located in areas containing the largest proportion of uninsured poor people; institutions with the largest area of influence in terms of population, and the highest levels of financial stress as measured by their deficits, the proportion of income obtained from funds for caring for the poor population not covered by demand subsidies and the proportion of expenditure assigned to personal services. Application of these targeting criteria will determine the universe of eligible bids. A second round of prioritization will make the definitive selection of subnational bodies within the targeted universe and subject to the program's budget constraints. At this stage, greater weight will be given to bids that achieve the highest relative expenditure saving, greatest medium-term sustainability and highest cost-benefit ratios. Consideration will also be given to other criteria, such as the cofinancing proposed by the subnational body, and its track record in terms of fulfilling commitments assumed with the national government in similar hospital reorganization processes.

3.7 **Component 1.** Execution of the activities in this component will be carried out through performance contracts, signed between the MPS and the corresponding subnational entity. The agreements will include the following three elements: (i) an evaluation matrix setting out the conditions to be fulfilled by the subnational body; (ii) performance contracts signed between the subnational entity and the corresponding IPS, including a matrix to evaluate the performance of participating IPSs in each subnational body, establishing baseline values and performance targets; and (iii) an internal forgivable loan contract to finance severance payments, obligations and settlements arising from staff downsizing. All of this documentation is available in the technical files of the program, and forms an integral part of the Operating Regulations.

3.8 Following the procedures described in the Operating Regulations, the sequence for gaining access to program funds will be as follows: (i) once the subnational entity has been selected, it will sign a performance contract with the MPS; (ii) when this has been signed, the subnational body will sign a second performance contract with each participating IPS; and (iii) lastly, the MHCP will sign the internal loan contract with the subnational entity. Disbursements will be released by the MCHP, following MPS authorization to the entity responsible for making the direct payments to the beneficiaries or staff being laid off, in accordance with Bank rules.

3.9 In order to guarantee the procedures, criteria and indicators specified in the Operating Regulations, the Bank will give its nonobjection before this documentation is signed.

3.10 The specific terms and activities of each agreement are described below:

a. **Evaluation matrix at the subnational entity level.** This matrix establishes baseline values generated from diagnostic studies, and sets annual targets for the following performance indicators over a five-year period: (i) adjustment and maintenance of staffing in line with demand, through severance payments and operational savings to be made on the basis of this adjustment; (ii) rationalization of expenses; (iii) production of services; (iv) quality of medical services; (v) IPS management; (vi) management of the subnational entity (DTS); and (vii) debt restructuring. These indicators are defined in detail in the program's Operating Regulations and logical framework. The targets will be established during contract negotiation, which will be carried out between MPS-PCU and the DTS, based on the diagnostic studies. Compliance with these targets by the IPSs and subnational bodies is the key objective of performance contracts. These will also set out the obligations to be met by the participating bodies, such as: (i) furnishing of documentation required for program monitoring; (ii) certification of compliance with legal provisions in the staff downsizing process and accurate response on the legality and veracity of the settlements entered into in the context of the staffing adjustment; and (iii) adoption of technical, administrative and financial measures as necessary for adequate program execution, oversight and audit. To manage the funds for severance payments, obligations, and wage settlements for staff laid off as a result of downsizing and rationalization in IPSs in the network, a special bank account will be opened, under the terms of and in accordance with the procedures set forth in the program Operating Regulations.

b. **Internal loan contract.** This instrument will be used to finance severance payments, obligations, and wage settlements for staff laid off as a result of downsizing and rationalization in IPSs in the network that were identified in the basic diagnostic study;[27] and it will make it possible to comply with the indicator on staff downsizing contained in the evaluation matrix. The MPS will be responsible for authorizing the release of funds for severance payments, obligations, and wage settlements, which will be carried out by the MHCP. In addition, the DAF will oversee the fiscal adjustment process at the subnational level; the General Public Credit Department (DGCP) will authorize loan contracts to subnational bodies; and the DGCP Debt Service Division will verify that the financial situation of the subnational body is up-to-date in its dealings with the national government.

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[27] The list of jobs to be eliminated forms part of the departmental bid for reorganization of the IPSs, based on the diagnostic study, and is part of the performance contract.

c. **Obligations of subnational entities.** The additional obligations of subnational bodies are specified in the respective performance contract. Specifically, the subnational body, through the DTS, will be responsible for: (i) setting up a team to provide technical assistance to the IPSs within its jurisdiction, in attaining the targets contained in the evaluation matrix; (ii) measurement and monitoring of progress in terms of the evaluation matrix and IPS indicators, reporting to the MPS-PCU every six months; (iii) financing of costs associated with the management of severance payments by the trust fund company or bank, which will be recognized as a program counterpart; (iv) financing of employment-related benefit obligations,[28] which will not be recognized as a program counterpart; and (v) other activities to support the attainment of evaluation matrix targets. To carry out these activities, MPS-PCU will provide technical assistance either directly, or through firms, nongovernmental organizations (NGOs) such as universities, or individual consultants to be hired by the PCU. The contents, timetable and scale of this technical assistance in each DTS will be specified in the performance contract, and represent essential inputs for achieving the targets.

d. **Financial conditions of internal forgivable loan contracts.** The following loan terms have been agreed for these contracts: (i) a minimum term of 10 years; (ii) the interest rate will be the rate used by Banco de la República in lending to the financial system (DTF);[29] (iii) repayment in nine equal, consecutive, annual installments, covering interest and principal; (iv) grace period of 18 months; and (v) in the event of default, the following payment sources will be drawn upon: (a) in the first instance, SGP funds, pursuant to Law 715 of 2001;[30] and (b) if necessary, other funds of the subnational entities that MHCP-DAF may identify to cover the loan amount.[31]

e. **Evaluation of performance contracts.** Every year, at least three months before the scheduled repayment date for each installment of the internal loan contract, a committee composed of representatives of the MPS, MHCP-DAF, and DNP will conduct an assessment of the evaluation matrix for the performance contracts, to determine whether or not to forgive the respective installment.[32] The respective installment payment for the internal loan contract will be forgiven if the targets

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28 Liabilities described in paragraph 1.30.

29 This interest rate is what the MHCP-DAF charges for adjustment loans with subnational entities. The rate guarantees the "return" on national government loans, as required by Decree Law 1133/99.

30 SGB health funds in a given fiscal period amount to 10 times the sum to be executed through internal loan contracts, so this will not represent a major burden for the SGB.

31 This includes 70% of the funds from the tax on spirits that Law 788 of 2002 earmarks for financing hospital reorganization.

32 The program monitoring and oversight system will provide inputs enabling the Contracts Evaluation Committee to verify compliance with targets and commitments by the subnational bodies participating in the program.

established in the evaluation matrix are fulfilled as of the assessment date. Failure to meet the targets established in the evaluation matrix means that the respective installment payment for the internal loan contract must be repaid, for which the subnational entity must use the sources of payment listed in paragraph 3.10(d). This assessment process will be repeated every year for each performance contract.

3.11 The possibility of forgiveness of repayment installments for the internal loan is the main incentive for subnational bodies to take steps to adapt and modernize the network, in order to enhance the quality and coverage of services and make more efficient use of existing resources. In addition, these loans would not be counted in the solvency and sustainability indicators provided for under the Subnational Borrowing Act, provided the adjustment targets are being complied with according to the timetable established in the performance contract. This would give subnational entities an additional incentive to meet the performance contract targets, since failure to do so would reduce their capacity to borrow in the future.

3.12 **Component 2**. This component has two subcomponents: one involving actions to strengthen the role of the MPS in monitoring, oversight and evaluation of the policy on health service provision; and the other relating to monitoring, oversight and evaluation of the performance contracts and the overall program.

3.13 **Monitoring and evaluation of the policy on health service provision.** The MPS, acting through the PCU, will contract technical assistance to support it in formulating, directing, implementing and evaluating health service provision policy, particularly public supply.

3.14 **Monitoring, oversight and evaluation of the program.** In addition, the PCU will monitor and oversee the program's internal actions, mainly through a specialist hired for this purpose. To successfully implement this function, the subnational bodies and the IPSs need to supply information of the expected quality on a timely basis. The PCU will hire the specialized advisory support needed to produce a procedural manual, support the DTSs and IPSs in compiling, organizing and presenting information, and support implementation and functioning of the program monitoring and oversight system. The PCU will also design basic parameters for evaluating program impact, and will hire a consulting firm to create the baseline and carry out midterm and final reviews. The audit process will be supervised by the MPS. A technical committee will be established, with the participation of the DNP, and will receive support from the advisory group to analyze and interpret the information generated by the evaluation, and participate in decision-making processes based thereon.

3.15 The **program will be managed** by the PCU, which will have a team of approximately six professionals to handle its technical, administrative, legal, financial and accounting aspects, among others. The PCU will contract program auditing in accordance with Bank policies on this subject. Program Operating

Regulations specify the structure and responsibilities of the PCU. **The selection and hiring of PCU technical and administrative-financial directors is a condition precedent to the initial disbursement of the loan proceeds.**

C. Operating Regulations

3.16 Program execution will be governed by the Operating Regulations, which set out the rules, procedures and regulations needed to execute each of the components, and specify the functions and obligations of the various actors involved. These regulations have already been agreed between the Bank and the country, and **their entry into effect will be a condition precedent to the first disbursement.**

D. Procurement of goods and services

3.17 Goods procurement and the hiring of consulting services will be carried out in accordance with the norms stipulated in the Bank's procurement policies and procedures. International competitive bidding (ICB) will be required for procurements financed partially or wholly from the loan proceeds in amounts exceeding the equivalent of US$350,000 in the case of goods procurement and US$200,000 for consulting services. These limits are justified by the interest shown in this project by potential suppliers, contractors and consultants, both national and international, and by previous experience of public bidding processes and the foreign participation that has been forthcoming.

3.18 Biding on smaller procurements will be carried out in accordance with national legislation.

3.19 In the case of consulting services for amounts below the US$200,000 threshold, bidding processes will adhere to the corresponding Bank procurement procedures, which in this case allow for procurement notices to be published only nationally, and permit the executing agency to waive the formal prequalification process for drawing up a short list of qualified firms to be invited to submit bids. On average between 10 and 12 local competitive bidding (LCB) processes are expected to be held to contract technical assistance actions or studies relating mainly to management upgrading in the MPS, DTS and IPS.

3.20 The program will not include any civil works tenders. The procurement plan is attached as Annex 2.

E. Revolving fund

3.21 The revolving fund will amount to 10% of the loan amount, equivalent to US$7.2 million, as authorized in OA-345. This is justified by an analysis of the planned flow of program disbursements. In the first two years of the program, the pace of execution will be faster, so the operational reorganization activities are concentrated in the more expensive institutions (highest level of care). In the second year of execution, international competitive bidding will be conducted for

procurement of computer platforms for the DTSs and the IPSs, with an estimated budget of US$10.7 million. Moreover, an average of 23 IPSs will be covered in the first two years and 42 in the remaining two years. This means that performance contracts will be executed and funds released simultaneously. The projected payments are estimated to average approximately US$1 million per IPS. The period for releasing the funds in each effective period is from May to December; therefore funds must be readily available to meet the obligations with the final beneficiaries. It is during this relatively short period that disbursement requests to the Bank must be processed simultaneously for all the IPSs that have signed performance contracts for that period. Those requests must also be accompanied by supporting documents, which have to be compiled in that very short window. The PCU will file semiannual statements on the revolving fund within 60 days following the end of each semester.

F. Execution period and disbursement schedule

3.22 The program will have an execution period lasting four years. It will be cofinanced by the government (20%) and by the Bank (80%). Table III-1 describes the anticipated flow of program disbursements (totals are approximate because of rounding).

Table III-1: Flow of disbursements
(thousands of US dollars)

Source	Year 1	Year 2	Year 3	Year 4	Total
IDB	14,000	20,000	17,600	18,400	72,000
Local	4,000	5,000	4,400	4,600	18,000
Total	20,000	25,000	22,000	23,000	90,000
%	23	28	24	25	100

G. Inspection and supervision

3.23 The interest rate, credit fee, and inspection and supervision fee mentioned in this document are established pursuant to document FN-568-3 Rev. and may be changed by the Board of Executive Directors, taking into account the available background information, as well as the respective Finance Department recommendation. In no case will the credit fee exceed 0.75%, or the inspection and supervision fee exceed 1% of the loan amount.[33]

[33] In no case will the inspection and supervision fee exceed, in a given six-month period, the amount that would result from dividing 1% of the loan amount by the number of six-month periods in the original disbursement period.

H. External audit

3.24 Throughout program execution, the borrower, acting through the PCU, will submit the program's annual financial statements to the Bank, within 120 days following the end of the corresponding fiscal period. The final program report will be filed within 120 days following the final disbursement. External audit of the program will be performed by a firm of independent auditors acceptable to the Bank, and in accordance with its requirements based on guidelines set out in the terms of reference for external audits in Bank-funded projects (document AF-400). The auditors will be chosen and hired using the procedures established in the document on bidding for external audits (document AF-200). Audit costs will form part of program expenses and be funded from the proceeds of the Bank loan.

I. Monitoring and evaluation

3.25 **Monitoring meetings and evaluation.** Monitoring meetings will be held between the MPS, the PCU and the Bank to review the functioning of the program from the institutional and operational points of view. Two six-monthly meetings will be held during the first year, and one in each of the following years. The corresponding dates will be scheduled between the Bank and the MPS. If necessary, according to the results of the review, appropriate measures will be taken to ensure satisfactory progress of the program.

3.26 **Progress reports.** During the program execution period, the PCU will present half-yearly progress reports to the Bank. These will contain details of activities carried out and progress made in each component, in terms of disbursements released and the physical targets agreed in the program's logical framework, together with reports and recommendations presented by independent bodies hired to execute the components.

3.27 **Evaluation.** The program will undergo a *midterm review and final evaluation*, both of which will be funded as part of the program. The *midterm review* will be held at the end of the second year of execution, and the *final evaluation* will be conducted at the end of the execution period. For the purpose of these evaluations, outcome indicators have been defined with baseline values and targets, and are included the logical framework (Annex 1). Indicators associated with the various *components* will emphasize progress made towards program targets, including the number of public hospitals that participated in the program, the level of savings generated through operational reorganization, implementation of appropriate referral and counter-referral systems within the public hospital networks, implementation and use of information systems in public hospitals and at the subnational level, and others. Logical framework indicators at the *purpose* level will measure progress made in improving the quality of services provided and the financial sustainability of the IPSs. At the *goal* level, the evaluation will measure gains in access to health services among the poorest population groups through an extension of insurance in

the subsidized health regime, in addition to user satisfaction levels in public hospitals, and reduction of the operating deficit among public hospitals nationwide.

3.28 The design of these evaluations will be varied. Firstly, there will be a simple monitoring of changes in quantitative performance indicators contained in the performance contracts for each IPS and each participating subnational entity. In addition, the functioning of the program will be analyzed as a whole, using process analysis methodologies (timeframes, quality, etc). An IPS control group will be established, and a quasi-experimental design will be used to contrast the performance of IPSs receiving intervention against similar IPSs that do not. In addition, user surveys will be conducted to gauge the perceived quality of services over time comparing the two groups of IPSs. Lastly, workers laid off through downsizing will be surveyed to assess their current labor-market status and evaluate the impact of the labor retraining activities included in the program.

3.29 The evaluations will start with a baseline, in coordination with the preparation of diagnostic studies and performance contracts in each IPS and subnational body. This will be followed by annual measurements that will serve as an input both for the annual performance reviews and for the midterm review and final evaluation reports. Evaluation will thus be ongoing throughout the program execution period.

3.30 The government has stated that it will not perform an ex post evaluation. Nonetheless, the data compiled for the midterm review and final evaluation, which have a baseline established, could serve as a direct input for an ex post evaluation of the program. Accordingly, the government has undertaken to compile the necessary data in relation to the outcome indicators defined at the *purpose* and *goal* levels in the logical framework, consistent with the new Bank policy (OP-305).

IV. VIABILITY AND RISKS

A. Legal and institutional viability

4.1 As regards legal viability, the program for Reorganization, Redesign and Modernization of Health Service Supply Networks is mentioned in Article 43 of Law 812 of 2003, which approves the four-year National Development Plan for 2003-2006.

4.2 In particular, the execution scheme for component 1, using performance contracts, and the loan agreement between the national government and the subnational body, are in keeping with the provisions of article 54, third paragraph, of Law 715 of 21 December 2001. This article allows the national government to extend forgivable loans to subnational bodies in order to implement the program for reorganization and modernization of public hospital networks, which will be considered as investment expenditures in the sector. It also establishes that: (i) such credits will not be counted in the solvency and sustainability indicators of Law 358 of 1997, provided the entity receiving them meets the requirements set by the national government for their forgiveness; and (ii) in the event of non-forgiveness, SGP incomes for the health service could be pledged to the national government.

4.3 In terms of the program's institutional viability, the MPS has the capacity, stability and preparedness for execution needed to manage the public hospital reorganization and modernization program. MPS staff who will supervise PCU tasks were involved in implementing the pilot scheme funded by the Bank in 1999; and in 2003 they also carried out an operational reorganization of public hospitals using performance contracts with very similar characteristics to those proposed in this program.

B. Fiscal and financial viability

4.4 The Government of Colombia has budgeted adequately for execution of this program. In the 2004 budget, the MPS and the MHCP have assigned fiscal funds for up to 100 billion Colombian pesos (about US$33 million) to finance activities in the operational reorganization of public hospitals. In addition, 100 million Colombian pesos have been assigned in the 2003-2006 investment plan for each year of program execution.

4.5 In the absence of the interventions envisaged in this program, it is calculated that the annual operating deficit will fluctuate between 221 billion Colombian pesos (about US$73 million) in 2003 and 371 billion pesos in 2009 (about US$123 million).[34] The initiatives proposed in this program will produce a

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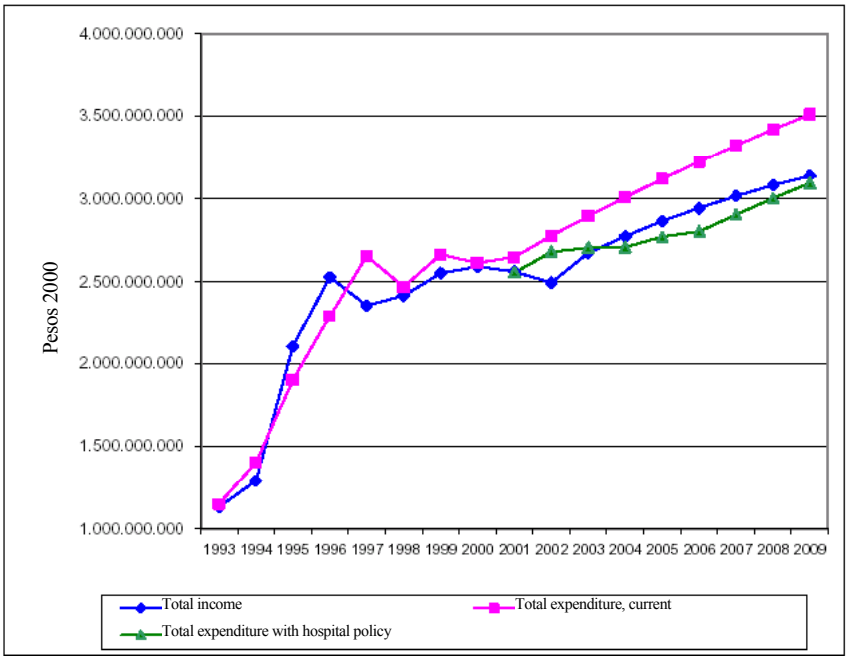
[34] CONPES document 3204. National Planning Department.

substantial reduction in the operating deficit of public hospitals over the medium term. The payback period for the investment implied by severance payments is estimated at 27 months for the whole program.[35] On the basis of fiscal savings likely to be achieved in 2004-2006, the program's financial internal rate of return (IRR)[36] is estimated at 15%. If one considers fiscal savings over the period 2004-2010, the IRR would rise to 28% (see Figure IV-1). The line representing public hospital expenditure includes the fiscal impact of the pilot program, the reorganization funded by the national government, and the estimated impact of the program.

Figure IV-1. The program's fiscal impact



C. Benefits, and social and environmental impact

4.6 The program is expected to improve the quality of services provided, mainly to the poorest groups and rural populations that rely on public institutions. The operational reorganization of public hospitals will help eliminate factors obstructing the move from supply subsidies to demand subsidies. This will facilitate progress towards universal health insurance, and improve equity in access to health services. The

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35 Rama M. (1999) The World Bank Economic Review, Vol. 13, No. 1, pages 23-66.

36 This relates program costs to the savings expected to result from the program. It does not include a quantification of associated social benefits and costs.

other outcome indicators for each component are specified in annex 1, the logical framework, attached to this document.

4.7 **SEQ/PTI classification.** As this is a health-sector program, the operation qualifies as a social equity enhancing project, as described in the indicative targets mandated by the Bank's Eighth General Increase in Resources (document AB-1704).

4.8 As many as 70% of public hospital users are estimated to have incomes below the poverty line, or live in a municipio reporting at least one unmet basic need (UBN) in the March 2000 Household Survey (ENH-2000). In addition, expansion of the subsidized regime as result of savings achieved by this program will occur among the poorest population groups, SISBEN 1 and 2, which encompass the two poorest quintiles of the income distribution. For these reasons, the operation also qualifies as a poverty-targeted investment (PTI). The borrower will be making use of the 10 percentage points in additional financing.

4.9 **Social and environmental impacts.** The program will not be financing infrastructure projects, so there are no environmental hazards in this sense. Component 1 includes activities to upgrade and oversee the handling of waste materials, and to minimize workers' health risks. This component will also finance technical assistance for the DTSs and IPSs to design and implement labor retraining and skill development for workers laid off as a result of IPS operational reorganization. These activities will result in trained labor being used in more efficient organizational structures, and generally help to reduce the negative social effects of this process. The government will monitor the staff downsizing process to ensure its gender and ethnic equity. The actions required to estimate demand include analysis and adaptation to take account of the specific ethnic and cultural groups existing in Colombia. It is thus hoped the program will have a positive impact on the health of indigenous and Afro-descendent population groups.

D. Risks

4.10 There is a risk that after the rationalization process implemented under the program, IPS staffing may expand once more. To guarantee the sustainability of the rationalization measures in the medium and long term, performance contracts will be signed for an estimated 10-year period, and annual compliance targets will be set. In an effort to keep fixed operating costs at an appropriate level, the performance contracts will include a clause establishing that IPS operating expenditures are to be financed with income from the sale of services and that the IPSs will not increase their staffing. Lastly, rationalization is linked to the subnational fiscal adjustment process, which will strengthen incentives to keep staffing at levels consistent with demand for the corresponding services. The program will also contribute to better implementation of the managed competition model envisaged in the reform, and the move from supply to demand subsidies, minimizing the risk of staffing levels expanding once more.

4.11 Rationalization of public supply to match current demand patterns, raises the possibility of health establishments being consolidated and staffing arrangements altered. This could generate a political risk for the program, which will be mitigated by actions to facilitate labor-market re-entry in addition to the severance payments to be funded in component 1 and a political commitment by the subnational authorities to be included in the performance contracts. This strategy has proven successful in the pilot restructuring program.

4.12 External factors, such as the fiscal and financial crisis among subnational bodies, pose a significant risk to the viability of public hospitals. Nonetheless, steps have already been taken to mitigate this. In order to strengthen the decentralization process and achieve medium and long-term sustainability among the subnational entities, the government has started to implement a set of measures aimed at strengthening subnational finances, with support from the Bank through the subnational fiscal reform sector program (1335/OC-CO). The aim of this is to produce viable entities that are in a position to fund their operations through internally generated incomes, promote regional development and guarantee payment of their liabilities. The actions proposed by this program are not only consistent with this process but form a major part of it, since they contribute to: (i) fiscal restructuring by attempting to systematically resolve problems of accumulated liabilities among entities participating in health service networks; and (ii) subnational fiscal viability, by extending binding budgetary constraints and reducing excessive current expenditure in the health sector.

PROGRAM FOR THE REORGANIZATION, REDESIGN AND MODERNIZATION OF HEALTH SERVICE NETWORKS (CO-0139)
LOGICAL FRAMEWORK

Narrative Summary	Achievement indicators [1]	Means of verification	Important assumptions
GOAL			
To support changes in public hospital management to ensure the technical and financial viability of public hospitals and extend insurance coverage within the SGSSS framework.	• Coverage of the subsidized health regime to have increased by 9 million new affiliates between 2003 and 2010. • Reduction of the intervened public hospitals' operating deficit from 221 billion pesos in 2003 to break even in 2010. • Average rate of user satisfaction with public hospitals to have risen from X% in 2003 to Y% to 2010.[2]	• MPS information system. • Financial statements of public hospitals. • National surveys - baseline and final evaluation.	• Macroeconomic and fiscal situation remains stable. • Domestic armed conflict does not worsen.
PURPOSE			**From purpose to goal**
To improve the efficiency, health-service quality, and financial sustainability of public hospital networks.	• Proportion of level 2 and level 3 public hospitals with healthy financial statements rises from 30% in 2003 to 60% by the end of the program, and is maintained over a three-year period following the end of the program. • At least 80% of the IPSs intervened to be in full compliance with targets for financial balance, service production and care quality by the end of the program, and maintained over a three-year period following the end of the program. • Quality of services provided in public hospitals to have improved between the	• Budget execution of public hospitals. • Baseline. • Matrices showing compliance with performance contracts. • Program monitoring and oversight system.	• Healthcare payment systems for the uninsured low-income population applied in accordance with national legislation. • Flow of resources for provision of rapid and timely services. • Appropriate implementation of Law 715/2001. • Commitment by governors, departmental secretaries or sectional health directorates, and IPS managers.

[1] Indicator baselines and targets will be fine-tuned in the light of data gathered in the process of creating the baseline.

[2] The baseline and targets for these indicators will be established in the performance contracts and in the logical framework for each IPS participating in the program.

Narrative Summary	Achievement indicators [1]	Means of verification	Important assumptions
	start and end of the program, and maintained over the following three years, measured by: [2] o Hospital mortality o Nosocomial infections o Speed of attention (waiting lists)		
COMPONENTS			**From Component to Purpose**
1. Operational reorganization of public hospital networks – Technical assistance for subnational health directorates (DTSs) for direction, coordination and administration of hospital networks. – Technical assistance to boost managerial capacity of public IPSs. – Adapt service supply to demand, downsizing staffing levels in the IPSs participating in the networks.	*By the end of the program* • At least 75% of the subnational health directorates (DTSs) in which the program intervened (estimated at 20) display effective actions of organization, direction, coordination and management of the services network at the subnational level. • At least 75% of the DTSs in which the program intervened (estimated at 20) have an operating center for information and regulating referrals and counter-referrals in the network. • At least 75% of the IPSs in which the program intervened (estimated at 132) have received the technical assistance package to enhance managerial capacity. • At least 75% of the IPSs in which the program intervened (estimated at 132) have implemented operational reorganization actions in accordance with program guidelines. • At least 20% reduction in staffing costs among IPSs receiving program intervention.	• Baseline. • Final program evaluation. • Matrices of compliance with performance contracts. • Program monitoring and oversight system. • Contracts with service-providing institutions. • Procedural and process manuals.	• Directorates have suitable tools and procedures to carry out IPS strengthening processes. • Adequate levels of connectivity. • Adequate and stable staffing levels in subnational bodies. • Political will and agreement between mayors and governors for adjustment and reorganization of service provision within the network focus. • Legal stability regarding human resource management.

Narrative Summary	Achievement indicators [1]	Means of verification	Important assumptions
2. Monitoring and evaluation – Technical assistance to the MPS for monitoring and evaluating the policy on health service provision. – Monitor and oversee program execution, and evaluate program impact.	*By the end of the program* • At least eight half-yearly evaluation reports produced by the monitoring and oversight system. • Final program evaluation reports produced.	• Program evaluation report.	• Commitment by governors, departmental secretaries or sectional health directorates, and IPS managers to provide the necessary information.
ACTIVITIES			
1.1 Technical assistance to DTSs for formulation, organization, direction and control of health-service networks.	US$1,500,000	• Loan management system. • PCU reports.	
1.2 Provision of management instruments and information technology tools for organization, direction and control of DTSs.	US$2,000,000		
1.3 Technical assistance to improve managerial and administrative capacities of the IPSs.	US$4,000,000		
1.4 Provision of management instruments and information technology tools to the IPSs for managerial and administrative processes.	US$10,000,000		
1.5 Payment of outstanding wages/benefits and severance awards to public IPS staff.	US$63,000,000		
2.1 Technical assistance for monitoring and evaluating the policy on health service provision.	US$1,700,000		

Narrative Summary	Achievement indicators [1]	Means of verification	Important assumptions
2.2 Technical assistance to implement the monitoring, oversight and program evaluation system.	US$1,500,000		

GENERAL PROCUREMENT PLAN

PROGRAM FOR THE REORGANIZATION, REDESIGN AND MODERNIZATION OF HEALTH SERVICE NETWORKS
(CO-0139)

Main project procurements	Year	Estimated budget (thousands US dollars equivalent)	Funding source		Procurement method	Prequalification	Provisional procurement notice
			IDB %	Local %		Yes/No	
1. Goods							
Hardware and software	2004	32	40	60	CP	No	Apr-04
Hardware and software	2005	10,689	40	60	ICB	No	Feb-05
2. Consulting services							
2.1 Impact evaluation	2004-2007	1,240	50	50	ICB	Yes	Feb-04
2.2 Monitoring and evaluation	2004-2007	431	50	50	LCB	No	Mar-04
2.3 Audit services	2004-2007	375	70	30	PI	Yes	Jun-04

ICB: International competitive bidding; **LCB**: Local competitive bidding; **CP**: Shopping; **CD**: Direct hiring without competition;
DM: Direct management; **QCBS**: Quality- and cost-based selection; **DC**: Consultancy contest; **IC**: Individual consultancy; **PI**: Private Invitation.